CENTERS FOR MEDICARE & MEDICAID SERVICES

Decision of the Administrator

In the case of:	Claim for:
Western Arizona Regional Medical Center **Provider**	**Provider Cost Reimbursement Determination for Cost Reporting Period Ending: 08/31/2001**
vs.	
Blue Cross /Blue Shield Association **Blue Cross & Blue Shield of Arizona**	**Review of:** **PRRB Dec. No. 2006-D19** **Dated: March 3, 2006**
Intermediary	

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for review of the decision of the Provider Reimbursement Review Board (Board). The review is during the 60-day period in §1878(f)(1) of the Social Security Act (Act), as amended (42 USC 1395oo(f)). Accordingly, the parties were notified of the Administrator's intention to review the Board's decision. Comments were received from the Center for Medicare Management requesting reversal of the Board's decision. All comments were timely received. Accordingly, this case is now before the Administrator for final agency review.

BACKGROUND

The Provider is a general acute care hospital located in Bullhead City, Arizona. For fiscal period ending August 31, 2001 the Provider operated 90 licensed and available inpatient beds. Prior to the enactment of the Benefit Improvements and Protection Act of 2000, Pub. Law 106-554(BIPA), urban hospitals with fewer than 100 available beds were eligible for Medicare disproportionate share (DSH) payments only if their DSH patient percentage exceeded 40 percent. However, with the passage of BIPA, an urban hospital with fewer than 100 beds became eligible for DSH payments if their DSH patient percent for discharges on or after April 1, 2001, was greater than 15 percent for a cost reporting period.

The Provider calculated its DSH percentage for discharges occurring on or after April 1, 2001 through the end of its cost reporting year (8/31/01) and determined a DSH percentage of 18.7 percent. The Provider applied that percentage to its Medicare payments for discharges on or after April 1, 2001. The Intermediary disallowed the calculation, claiming that the Provider's DSH percentage for the entire cost reporting period (September 1, 2000 through August 31, 2001) was less than 15 percent. The Provider appealed.

ISSUE AND BOARD'S DECISION

The issue is whether the Intermediary's adjustment of the Provider's DSH calculation was based upon a proper interpretation of the Medicare DSH statute as amended by the BIPA of 2000.

A majority of the Board held that the Intermediary incorrectly calculated the Provider disproportionate patient percentage (DPP). The Board majority found that the Intermediary's use of a single aggregated patient percentage ignored the impact of the BIPA 2000 amendment. The Board majority determined that §211(a) of BIPA 2000 and the corresponding regulation at 42 C.F.R. §412.106 required Intermediaries to calculate two distinct DPPs for each provider; one for discharges occurring prior to April 1, 2001 and another for discharges occurring on or after April 1, 2001.

In reaching this conclusion, the Board majority relied on CMS' discussion of the amendment found in the August 1, 2001 Federal Register. There CMS stated:

> This means that the legislation is effective with discharges occurring on or after April 1, 2001, but not before. Therefore, fiscal intermediaries are required to determine whether a hospital meets the thresholds in place either before or after April 1, 2001 by applying the DSH patient percentage in the formula to each separate period.[1]

Finally, the Board likened the application of §211(a) of BIPA 2000 to the counting of §1115 waiver days for discharges occurring on or after January 20, 2000. CMS explained in the August 1, 2000 Federal Register that:

> Therefore, it is possible that a hospital will qualify for DSH payments as of January 20, 2000, whereas it did not qualify before January 20, 2000, and it should be paid accordingly. In other words, a hospital in

[1] 66 Fed. Reg. 39828, 39882 (Aug. 1, 2001).

> that situation would receive Medicare DSH payments beginning January 20, 2000.[2]

Accordingly, the Board majority concluded that the Provider was entitled to a DSH adjustment on its 2001 cost report for discharges occurring on or after April 1, 2001 to the end of the cost reporting period.

Two members of the Board dissented holding that §1886(d) (5) (f) (v) of the Act required only one DPP and that DPP is to be compared to the two thresholds. Furthermore, the regulation at 42 C.F.R. §412.106(b) similarly contemplated the computation of a single DPP based on a single exercise of adding together the results of the first and second computations.

SUMMARY OF COMMENTS

CMM commented requesting that the Administrator review and reverse the Board's decision. CMM argued that §211(a) of BIPA 2000 only revised the eligibility threshold for certain hospitals to receive Medicare DSH payments. BIPA 2000 did not address a revision to the DPP calculation.

CMM explained that the DSH adjustment calculation has two parts: The DPP calculation and the adjustment amount computation. With data provided by the Provider and CMS, the Intermediary computes the DPP. If the DPP is equal to, or greater, than, the eligibility threshold the hospital is entitled to a Medicare DSH adjustment. Next, the Intermediary computes the adjustment amount by using the DPP in a statutorily defined adjustment computation. The resulting DSH adjustment percentage is applied to every payment made for a discharge under the inpatient prospective payment system (IPPS).

For example, under current law, an urban hospital with under 100 beds (like the Provider) would need to have a DPP of approximately 19 percent to have a DSH adjustment of approximately 5 percent. If the hospital has a Medicare DSH adjustment of 5 percent and is being paid $1000 for a discharge, the hospital would receive $1050 ($1000 for the discharge plus a $50 Medicare DSH payment ($1000 x 5 percent). Section 211(a) of BIPA revised the Medicare DSH adjustment by entitling all hospitals with a DPP of 15 percent or more a Medicare DSH adjustment to payments for discharges occurring on or after April 1, 2001.

Finally, CMM disagreed with the Board's comparison of §211(a) of BIPA 2000 to the counting of §1115 waiver days for charges occurring on or after January 20,

[2] 65 Fed. Reg. 47086

2000. In this case, Congress changed the qualifying threshold for Medicare DSH adjustment; the DPP calculation was not modified.

DISCUSSION

The entire record, which was furnished by the Board, has been examined, including all correspondence, position papers, and exhibits. The Administrator has reviewed the Board's decision. All comments received timely are included in the record and have been considered.

Pursuant to §1886(d) (5) (F) (i) of the Act, the Secretary is mandated to provide an additional payment per patient discharge, "for hospitals serving a significantly disproportionate number of low-income patients…."[3] To be eligible for the additional payment, a hospital must meet certain criteria, concerning, inter alia, its disproportionate patient percentage. Generally, the location and bed size of a hospital determines the threshold patient percentage amount to qualify for a DSH payment.

Under §1886(d)(5)(F)(v) of the Act, as it existed prior to the enactment of BIPA 2000, a hospital that was located in an urban area and has 100 or more beds was eligible for the additional DSH payment, if its disproportionate patient percentage was 15 percent. However, if the urban hospital has less than 100 beds, it had to have a disproportionate patient percentage of 40 percent to be eligible for the DSH adjustment.[4]

Section 211(a) of BIPA 2000 amended §1886(d) (5) (F) (v) of the Act, to provide that, beginning with discharges occurring on, or after April, 2001, the qualifying threshold is reduced to 15 percent for all hospitals.

This particular case centers on whether §1886(d) (5) (F) (v) of the Act requires CMS to calculate two separate DPP, or just one DPP for the fiscal period in dispute. The Provider contends that §1886(d)(5)(F)(v) of the Act, as amended, requires the calculation of a separate DSH percentage; one for discharges occurring prior to April 1, 2001, and another for discharges occurring on, or after, April 1, 2001. The Provider

[3] Section 9105 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Pub. L. No. 99-272). See also 51 Fed. Reg. 16772, 16773-16776 (1986).

[4] Id. For the pertinent cost year, rural hospitals with more than 100 beds but less than 500 beds must have a disproportionate patient percentage of 30 percent to be eligible for the DSH adjustment.

contends that for the period April 1, 2001 through August 31, 2001 its DSH percentage was 18.7 percent.[5]

The Administrator does not agree. The Administrator finds that the Provider's DSH percentage for fiscal year 2001 was 11.49 percent.[6] The Administrator finds that § 1886(d) (5) (F) (v) of the Act requires that only one DPP be calculated for a cost reporting period and that DPP is to be compared to the two thresholds. Section 1886(d) (5) (F) (v) of the Act states:

> In this subparagraph, a hospital "serves a significantly disproportionate number of low income patients" for a cost reporting period if the hospital has a disproportionate patient percentage (as defined in clause (vi)) for that period which equals, or exceeds—
>
> …
>
> (III) 40 percent (or 15 percent, for discharges occurring on or after April 1, 2001), if the hospital is located in an urban area and has less than 100 beds…. (Emphasis added).

In response to comments concerning the amendment to §1886(d) (5) (F) (v) of the Act CMS stated:

> *Response:* Section 211(a) of Public Law 106-554 amended section 1886(d)(5)(F) of the Act to change the qualifying thresholds for the DSH payment adjustment to 15 percent for all hospital types, effective with discharges occurring on or after April 1, 2001. This means that the legislation is effective with discharges occurring on or after April 1, 2001, but not before. Therefore, fiscal intermediaries are required to determine whether a hospital meets the thresholds in place either before or after April 1, 2001, by applying the DSH patient percentage in the formula to each separate period. Days are counted based on the date of discharge. In other words, a hospital stay would be counted in the cost reporting year during which the patient was discharged.[7]

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[5] Provider's Exhibit P-3. Medicare SSI percentage of 0.0267 plus Medicaid percentage of 0.1602343 (Total Medicaid Days of 1395 divided by total acute patient days for the period of 8706) = 0.1869343 or 18.7 percent.

[6] Intermediary's Exhibit I-4. Medicare SSI percentage of 0.0267 plus Medicaid percentage of 0.0881754 (Total Medicaid Days for the cost reporting period of 2,123 Title XIX days divided by 24,077 total patient days for the cost reporting period) = 0.1148754 or 11.49 percent.

[7] Supra note 1.

The Administrator finds that the above passage means that only one DPP is to be calculated for the entire cost reporting period, regardless of whether the hospital becomes eligible as of April 1, 2001. The Administrator also finds that, once the DPP is calculated, this DPP is then applied to each separate period (i.e., before and after April 1, 2001). For each period the Provider qualifies for DSH payment, a separate DSH payment calculation will be made. It does not mean that two DPPs should be calculated during a 12 month period.

This is consistent with the regulation controlling the computation of the DPP. The regulation at 42 C.F.R. §412.106(b) (3) and (4) provides that:

> (b) *Determination of a hospital's disproportionate patient percentage.*
> (1) *General rule.* A hospital's disproportionate patient percentage is determined by adding the results of two computations and expressing that sum as a percentage.
> (2) *First computation: Federal fiscal year.* For each month of the Federal fiscal year in which the hospital's cost reporting period begins, CMS-
> (i) Determines the number of covered patient days that-
> (A) Are associated with discharges occurring during each month; and
> (B) Are furnished to patients who during that month were entitled to both Medicare Part A and SSI, excluding those patients who received only State supplementation;
> (ii) Adds the results for the whole period: and
> (iii) Divides the number determined under paragraph (b) (2) (ii) of this section by the total number of patient days that-
> (3) *First computation: Cost reporting period*. If a hospital prefers that CMS use its cost reporting period instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request including the hospital's name provider number, and cost reporting period end date. This exception will be performed once per hospital per cost reporting period, and the resulting percentage becomes the hospital's official Medicare Part A/SSI percentage for that period.
> (4) Second computation. The fiscal intermediary determines, for the same cost reporting period used for the first computation, the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period….

The regulation at paragraph (5) provides that:

> (5) *Disproportionate patient percentage.* The intermediary adds the results of the first computation made under either paragraph (b) (2) or (b) (3) of this section and the second computation made under paragraph (b) (4) of this section and expresses that sum as a percentage. This is the hospital's disproportionate patient percentage, and is used in paragraph (c) of this section.

Paragraph (c) sets forth the criteria for classification as a disproportionate share hospital and incorporates therein the changes enacted by §211(a) of BIPA. Thus, this regulation contemplates only one DPP for a cost reporting period. The only option available to the Provider is whether that DPP will be based on the Provider's cost reporting period or the Federal fiscal year.

The Administrator further finds that this determination is support by Provider Reimbursement Manual (PRM) Part II—Provider Cost Reporting Forms & Instructions §3630 which shows that only one DPP is used to calculate the DSH payment for a fiscal year. The PRM states:

> If your hospital becomes eligible for DSH as of April 1, 2001, AND your cost reporting period overlaps April 1, 2001, enter the Allowable DSH Percentage into E Part A Line 4:03, Column 1.01. The software will then calculate the DSH Adjustment on Line 4.04, Column 1.01, using the DRG Amount entered into Line 1.07 (discharges from April 1, 2001 through September 30, 2001). If your hospital was eligible for DSH prior to April 1, 2001, DO NOT use Column 1.01 for this purpose.

Thus, applying the relevant law and program policy to the foregoing facts, the Administrator finds that the Intermediary properly interpreted §1886(d) (5) (F) (v) of the Act and the regulations at 42 C.F.R. §412.106(b) by calculating the Provider's DPP only once during the cost reporting period in dispute.

DECISION

The decision of the Board is reversed in accordance with the foregoing opinion.

THIS CONSTITUTES THE FINAL ADMINISTRATIVE DECISION OF THE SECRETARY OF HEALTH AND HUMAN SERVICES

Date: 4/20/06 /s/

Leslie V. Norwalk, Esq.
Deputy Administrator
Centers for Medicare & Medicaid Services